SECTION: HUMAN RESOURCES	REFERENCE NUMBER: A9
SUBJECT: ON THE JOB INJURY	EFFECTIVE DATE: 09/01/2018
FROM: KELLY KUENSTLER, CITY MANAGER	LAST REVISION DATE: 08/16/2008

A. POLICY STATEMENT

The City of Leon Valley is vitally concerned about the health and safety of every employee, and makes every effort to provide safe working conditions for all employees, to eliminate unsafe working conditions that are discovered, and to provide quality care to those employees who suffer on-the-job injuries/illnesses. The following procedures have been implemented to ensure these goals are met. In the event of injury, illness, or any other medical condition which limits an employee's capability to fully perform all the essential functions of their job, the City shall ATTEMPT to make reasonable accommodations to allow the employee to perform modified duty. Failure to report an accident promptly or to follow the established procedures for treatment will be considered a policy violation and subject to disciplinary action.

B. PURPOSE

1. To establish a policy and implement procedures for reporting, treating, and investigating on-the-job injuries.

2. To regulate absences due to on-the-job injuries.

3. To limit the City's liability as an employer for on-the-job injuries.

C. SCOPE

This policy applies to all City employees, including part time employees, temporary employees, volunteers, elected officials, uniformed police, and firefighters.

D. OBJECTIVES

1. To identify the steps taken to ensure that on-the-job injuries are reported promptly and accurately.

2. To establish the process for accounting for employees absences from the job due to an on-the-job injury.

3. To inform the employee of their responsibilities while off the job.

4. To ensure Supervisors and Department Heads know what their responsibilities are in accounting for employee absences due to an on-the-job injury.

E. DEFINITIONS

1. **Accident** – An unexpected and unforeseen event, happening suddenly or violently, with or without human fault.

2. **On-The-Job Injury –** Damage or harm to the physical structure of the body, sustained in the course of employment, and may include a disease or infection.

3. **Restricted Duty** – A limitation placed on an employee by a medical doctor which identifies a medical condition which prevents the employee from performing some essential element of the job. Limitations are usually imposed for a specified period of time.

4. **Reasonable Accommodation** – An adjustment or change to "accommodate" or make fair, a system for an individual based on a proven need. A reasonable accommodation may include temporary transfer of the employee to another job within the department. The City is under no obligation to provide a job at the same level of compensation.

5. **Salary Continuation Program** – Arrangement to continue an employee's salary in the form of payments for a certain period of time.

F. RESPONSIBILITIES

1. The Human Recourses Director is responsible for:

   a. The administration of this policy.

b. Maintaining contact with the City's workers compensation insurance carrier.

c. Assisting Department Heads and Supervisors in the implementation and enforcement of this policy.

2. Department Heads or Designated Representatives are responsible for:

a. Enforcing compliance of this policy.

b. Providing qualified supervision and a safe work place for their employees.

c. Ensuring that employees report any on-the-job injury and seek medical treatment when necessary.

d. Informing subordinate employees of this policy through distribution of this directive.

e. Counseling supervisors individually on this policy.

3. All City employees including volunteers, and reserve police officers are responsible for:

a. Complying with the policies outlined in this procedural directive.

b. Reporting all on-the-job injuries to their Supervisor within 24 (twenty-four) hours of the accident or the claim may be denied due to being untimely.

c. Seeking medical treatment if and when necessary.

G. **POLICY / PROCEDURES**

All employees are entitled to Worker's Compensation benefits. In addition to Worker's Compensation benefits the City has established a Salary Continuation Program. Workers Compensation benefits will be supplemented with paid leave for eligible employees in accordance with the appropriate leave polices as outlined in the City's Personnel Manual.

Medical Treatment

1. **Life Threatening Injuries:** If the injury is very serious, the injured employee should not be moved and an ambulance should be called.
    a. In an emergency, wherein the below procedures may endanger the employee, the employee is to seek the necessary medical attention from the nearest physician or go directly to a hospital's emergency room.
    b. The employee's supervisor must be notified as soon as possible as to the situation.

2. **Non-Life Threatening Injuries:** Report the injury immediately to their Department Head or his/her designated representative, fill out a First Report of Injury, and seek medical care. For On-the-job injuries that are minor, superficial, or otherwise not serious, the employee at his/her discretion may either delay seeking medical treatment or forego medical care. The decision to delay or forego medical treatment does not change the requirement that an employee must report the injury.

    a. Transportation of sick or injured employees to the physician or hospital should be handled as follows:

        i. Non-emergency transportation: the affected employee may transport themselves, provided the illness or injury does not endanger the employee or affect safe driving ability.

        ii. If the injured Employee cannot transport themself, the Department Head or his/her designated representative may authorize the use of a City vehicle and driver to drive the injured worker to the hospital or physician for treatment.

        iii. An ambulance or other such emergency units shall be called for transporting an employee who is or may be seriously injured.

Reporting Accidents

1. All on-the-job injury accidents will be reported as soon as possible by the employee to their Department Head or his/her designated representative. If the employee is not clinically able to submit the written notification, such notification may be made by an individual representing the employee or on behalf of the employee. Failure to report the injury within 24 (twenty-four) hours of the accident could cause the claim to be rejected

as untimely and require that the employee pay for the costs associated with the injury.

2. The employee will complete a First Report of Injury or Illness Form TWCC-1 **(Attachment A)** for all on-the-job injuries or they will provide to their supervisor the information necessary to complete the required First Report of Injury or Illness Form **(Attachment A)**. This will be forwarded to the Human Resources Director within 24 hours of the incident. An Investigation & Analysis Report **(Attachment B)** will also be completed by the Department Head or his/her designated representative and forwarded to the Human Resources Director within three (3) working days of the incident or notification of the accident.

3. If the employee is seeking medical treatment, the supervisor must contact the Human Resources Director, Immediately. The on-the-job injured employee should **NOT** give their personal insurance information to the treating physician. Instead, the Human Resources Director will provide a treatment Authorization form and a copy of their job description to the treating physician.

4. The Texas Municipal League Intergovernmental Risk Pool (TML-IRP) is the City's Workers' Compensation insurance provider.

    a. TML-IRP has a Political Subdivision Workers' Compensation Physicians Alliance;

    b. Employees injured on the job may only seek treatment from providers within the Alliance; however, if the injury is severe, the employee may go to nearby emergency room;

    c. Employees may locate a list of authorized physicians within the Alliance at www.pswca.org or by contacting the Human Resources Director.

5. After medical treatment from a TML-IRP authorized worker's compensation physician, the injured employee must return to work with a Work & Medical Status Report (DWC Form 73), given to them by the treating Physician.

6. The Human Resources Director will file all necessary reports with the City's insurance carrier, TML-IRP.

7. If the employee is placed on modified duty, the employee must follow Procedural Directive A4

8. If an employee is injured to the extent that they cannot return to work, they must notify their supervisor within 24 (twenty-four) hours, who in turn will notify the Department Head or his/her designated representative for the completion of the appropriate paperwork.

9. All bills sent to the employee by a provider for treatment must be submitted promptly to the Human Resources Director to ensure the proper processing for payment.

Absences

1. If an employee loses time from work due to an on-the-job injury, they are required to see a physician immediately and submit a Work and Medical Status Certificate Form from the treating physician after receiving treatment, or at the beginning of the next work day. The employee is responsible for the delivery of this form to the Department Head or his/her designated representative. If the employee is medically unable to return this form in person, they must ensure that this is so stated on the form by their physician. The employee must telephone the Department Head or his/her designated representative and inform him/her of this medical inability to deliver the form so that arrangements can be made for the form to be picked up.

2. Employees are required to keep all scheduled medical appointments. If an employee is unable to keep a scheduled medical examination, they must call their Department Head or his/her designated representative prior to the scheduled appointment and explain why their scheduled examination was not kept. An employee must advise their Department Head or his/her designated representative as to the scheduled date of the next examination. The employee shall obtain a separate completed doctor's slip for each subsequent visit to the doctor or hospital.

3. In order to return to duty after an absence due to an on-the-job injury, an employee must submit a Work and Medical Status Certificate Form (CWC FORM 73) signed by their physician stating that they can return to duty and the date in which they can return. After an employee receives this form, they must contact the Department Head or his/her designated representative for instructions regarding when and where to report.

4. An employee is expected to return to work on the date stated on the Work and Medical Status Certificate Form, given to them by their treating Physician. If an employee is unable to report to work on that date, they must call the Department Head or his/her designated representative during work hours to advise them why they cannot report to work. An employee is subject to having their salary continuation benefits suspended and

facing possible disciplinary action if they do not report for duty on the day they are released by a physician.

5. While an employee is on leave, they can be required to attend safety classes or other job related learning classes given by the Department. An employee can be asked to come to the office to discuss the injury and / or other job related matters. Attendance upon reasonable notification is mandatory unless a physician's statement shows a physical inability to attend such classes or meetings.

6. An employee must clearly understand that while on leave, they are obligated as part of their job responsibilities to follow these procedures. While on leave, **THEIR PRIMARY "JOB" IS TO RECOVER FROM THEIR INJURY**, to cooperate with the City in following these procedures, to provide information as reasonably requested by the Department, and to carry out other reasonable requests (such as attending meetings or classes). Telephone calls and or visits to an employee's home address or place of recovery will be made periodically by the employee's Department Head or his/her designated representative to ensure adherence to this procedure and other rules and regulations. During normal working hours an employee is directed to refrain from activities that are not conducive to their recovery. During normal off duty hours, an employee is expected to do nothing to aggravate their medical condition. If an employee has any questions regarding these responsibilities, they should ask their Department Head or his/her designated representative.

7. An employee cannot hold other employment, including previously approved outside employment, while on leave.

8. An employee is required to immediately report any change in home address, phone number, or place of recovery. These changes will be reported to the Department Head or his/her designated representative.

9. When an on-the-job injury requires professional medical attention, the injured employee shall obtain a dated medical report (doctors slip) from the attending physician at the time of treatment. The doctor's slip shall state if the employee is medically released for full duty or restricted duty. If the doctor recommends restricted duty, the report shall list the limitations.

10. An employee returning to duty after a job-related disability, illness, injury, or medical condition must provide the Human Resources Department with a signed and completed medical report form the physician indicating the employee's full release to return to work.

11. All employees who receive any type of leave because of an on-the-job injury are required to follow the policies listed above. Failure to comply with any of these policies or other rules or regulations may result in the suspension of the City's Salary Continuation Program and subject the employee to possible disciplinary action. An employee who is authorized to be off duty due to an on-the-job injury shall be subject to disciplinary action if they:

    a. Fail or refuse to follow the instructions stated in this policy.

    b. Engage in part-time or full-time work which is inconsistent with their injury or illness.

    c. Falsify or misrepresent their physical condition or disability.

    d. Fail or refuse to follow instructions of the treating physician.

    e. Fail to report for examination or treatment as directed by the treating physician.

    f. Refuse to return to regular or modified duty when authorized by the treating physician and offered by the City.

H. ATTACHMENTS

A - First Report of Injury or Illness Form
(Fillable PDF can be located here: http://www.tdi.texas.gov/forms/dwc/dwc001rpt.pdf)
B - Incident Investigation and Analysis Report

Attachment A

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex F ☐ M ☐
3. Social Security Number
4. Home Phone ( )
5. Date of Birth (m-d-y)
6. Does the Employee Speak English? If No, Specify Language
YES ☐ NO ☐
7. Race White ☐ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O.Box)
City State Zip Code

16. Date of Injury (m-d-y)
16. Time of Injury : am ☐ pm ☐
17. Date Last Time Began (m-d-y)
18. Nature of Injury*
19. Part of Body Injured or Exposed*
20. How and Why Injury/Illness Occurred*
21. Was employee doing his regular job? YES ☐ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
Street or P.O. Box County
City State Zip Code
24. Cause of Injury(fall, tool, machine, etc.)*
25. List Witnesses
26. Return to work date/if expected (m-d-y)
27. Did employee die? YES ☐ NO ☐
28. Supervisor's Name
29. Date Reported (m-d-y)

30. Date of Hire (m-d-y)
31. Was employee hired or recruited in Texas? YES ☐ NO ☐
32. Length of Service in Current Position Months _____ Years _____
33. Length of Service in Occupation Months _____ Years _____
34. Employee Payroll Classification Code
35. Occupation of Injured Worker
36. Rate of Pay at this Job $_____Hourly $_____Weekly
37. Full Work Week is: _____ Hours _____ Days
38. Last Paycheck was: $_____ for _____ Hours or _____ Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐
40. Name and Title of Person Completing Form
41. Name of Business
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ( )
City State Zip Code
43. Business Location (if different from mailing address) Number and Street
City State Zip Code
44. Federal Tax Identification Number
45. Primary North American Industry Classification System Code (6 digit)
46. Specific NAICS Code (6 digit)
47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

TWCC 1 (Rev. 07/03) Texas Workers' Compensation Commission

Incident Investigation and Analysis Report
**** To be completed and filed within 5 days of Incident ****

Date of Report:_____ Date of Incident:_____

Name of Employee Involved: _____ Department:_____

Employees' Supervisor: _____ Time of Incident:_____

Type of Incident:
❑ Striking Against
❑ Exposure to heat or cold
❑ Vehicle Struck by Other
❑: Vehicle Struck Other

Photos Included: Yes ❑ No ❑
❑ Caught in/between
❑ Lifting or overexertion
❑ Exposure to toxic material
❑ Fall
❑ Contact w/ sharp object
❑ Unknown Fire or explosion
❑ Unknown
Other _____

Type of Injury of Illness:
❑ Abrasion (Scrape)
❑ Contusion (bruise)
❑ Laceration (cut)
❑ Puncture Wound
❑ Strain/Sprain
❑ Fracture or break
❑ Burn
❑ Head Injury
❑ Respiratory Distress
❑ Skin Disease
❑ Poisoning
❑ Eye Injury
❑ Amputation
❑ Fatality
❑ Other

Person received medical attention: Yes ❑ No ❑

Body Part Affected:_____ Date of Return to Duty:_____

****Texas Workers' Compensation Claim - 1st Report of Injury form must be attached for any injury!**

EMPLOYEE'S REPORT OF INCIDENT: Description of Incident: (as revealed by investigation)
Was a Police Report Filed? Yes ❑ No ❑

Location of Incident occurrence:_____

Names of Witnesses and Phone Numbers:_____

_____

Give detailed account of incident: _____

_____

_____

Was personal protective equipment required for performing this? **Yes ❑ No ❑**

If yes, was it used? **Yes ❑ No ❑** Was it used correctly? **Yes ❑ No ❑**

Employee's Signature:_____Date:_____

SUPERVISOR'S ACCOUNT OF INCIDENT: Description of Incident: (as revealed by investigation)

Location of incident occurrence:_____

Names of witnesses and phone numbers:_____

_____

Give detailed account of incident: _____

_____

_____

_____

Were these conditions correctable? _____

_____

Did UNSAFE ACTS by the employee or others contribute to the incident? **Yes** ❑ **No** ❑

If yes, list and describe what UNSAFE ACTS: _____

_____

Do you feel this incident could have been prevented and how?_____

_____

_____

Was personal protective equipment required for performing this? **Yes** ❑ **No** ❑

If yes was it used? **Yes**❑ **No** ❑ Was it used correctly **Yes**❑ **No**❑

If not, why?_____

Cause(s) of Incident: Basics Causes:

❑ Faulty Design/Layout
❑ Faulty Equipment or Maintenance of such
❑ Personal Limitation
❑ Failure to Follow Established Safety Policies
❑ Lack of Experience
❑ Policy
❑ Equipment Construction
❑ Insufficient Job Training
❑ Supervision
❑ Unknown
❑ Other _____

Prevention of Future Incidents:

What immediate action was taken? _____

_____

Corrective Action: (Identify persons with assigned responsibility for actions and completion date of action(s))

_____

_____

Cost of repair or estimates for repair for property damage are:_____

Supervisor: _____ Date: _____

Comments/Recommendations of Department Head:_____

_____

Department Head: _____ Date: _____

Attachments: Police Report ❑ Cost Estimate/Repair ❑ Photos of Damage ❑
Return-to-Work Medical Release ❑ TWCC-1 Report ❑